Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
PO BOX 9705
MCALLEN TX 78502

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-0036-01

MFDR Date Received
September 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Documentation applies to Rule 133.2"

Amount in Dispute: $308.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's documentation does not support treatment in response to an emergency as defined by Rule 133.2."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2011	Outpatient Hospital Services	$308.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code § 133.2 defines an emergency.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 18, 2011
   - CAC-85 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 728 – THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824

- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

EXPLANATION OF BENEFITS DATED AUGUST 15, 2011

- CAC-85 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 724 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION OF SERVICES FOR INFORMATION CALL 1-800-937-6824.
- 728 – THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824
- 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

Issues

1. Does the disputed service(s) meet the definition of emergency service?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code, 899 - DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCODANCE WITH RULE 133.2. 28 Texas Administrative Code §133.2(4)(A) states that, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including sever pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part." The medical documentation does not meet the definition of an emergency pursuant to §133.2(4)(A). For example:
    a. Page 14 of "Complete Record" indicates, "Pain is exacerbated by nothing."
2. The Division concludes that the denial code is supported as the definition of medical emergency pursuant to TAC 133.2(4)(A) is not met.
3. Review of the submitted documentation finds that reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 22 , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.